

Addressing Health Equity Requires the Tools of Quality Improvement

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MINNESOTA IS A STATE WHICH PRIDES ITSELF on some of the overall highest quality health care in the nation, yet we're vexed by some of the worst health disparities and outcomes for communities of color and other vulnerable and underserved populations. Minnesota Department of Health Commissioner Jan Malcolm expands on the systemic issues in her Stratis Health board column about why health equity matters for the state.

Emerging payment models tied to health outcomes are allowing health care organizations to act in new ways to address disparity issues. Stratis Health brings to the table quality improvement methods and expertise—such as community planning and capacity building, data gathering and analysis, and best practice sharing—as tools that aid the transformation of health care in ways that achieve health equity.

In working to reduce unnecessary hospital readmissions for Medicare consumers, Stratis Health helped form 10 care coordination communities across Minnesota in geographic areas that show disparities in care. Our West Metro Coordination of Care Community is piloting an effort to identify and address social determinants of health. A diverse range of partners—including acute and post-acute care settings, senior living, and a fire department—are starting to screen individuals who have



had a health crisis reflecting social factors. With that data, they will identify resources to address needs, build relationships with the resource organizations, and create a discharge planning process that connects patients to these local resources.

People in rural communities experience significant health disparities. Stratis Health, in conjunction with our partners at the University of Iowa's RUPRI Center for Rural Health Policy Analysis at the College of Public Health, is sharing innovative care delivery approaches to transition rural communities and health care organizations to a high performance health system. Rural communities are innovating to reduce disparities by:

- ✦ Using predictive analytics, which includes social determinants of health, to assess risk level for health services and better target services and support.
- ✦ Integrating high-quality legal services into clinical and community support ser-

THIS ISSUE

Health is Not an Equal Opportunity 2

Technology in Support of Equity 3

Minnesota Health Systems Making Health Equity Actionable 4

Reshaping organizational culture.

Disparities in Minnesota Hospital Readmission Rates 6

Accelerating Health Care Affordability Event 7

vices offered to low-income chronically-ill patients.

- ✦ Offering a community reinvestment program that prioritizes diverse organizations working together to achieve quality targets.

Recognizing that lack of affordability and waste in the system causes disparities in clinical care, and emotional, and financial harm for patients, Stratis Health is co-convening "Accelerating Affordability" with ICSI and MN Community Measurement. I invite Minnesota's public and private sector leaders to join me at this November 29 event so, together, we can envision the ideal future and identify actions to advance affordability.

We need persistence, innovation, and collaboration to make progress in reducing disparities and improving health equity in Minnesota. We also need actionable tools, and Stratis Health will bring the quality improvement toolbox. ○

Health is Not an Equal Opportunity

WE MINNESOTANS ARE PROUD of our high rankings among the states on many measures, including economic growth and prosperity, educational attainment, and health. However, those high rankings are about averages, and they conceal some of the worst disparities in the nation on the same measures.

Researchers at the Minnesota Department of Health (MDH) and elsewhere have been aware of stark differences in health outcomes for some populations—for decades. The public health and health care communities have made efforts to respond, but largely feel as though we have been “running in place.”

Under Commissioner Ed Ehlinger’s leadership, MDH issued a remarkable report to the legislature in 2014 called *Advancing Health Equity in Minnesota*. The report again detailed the extent of disparities among various populations and connected causes to underlying community conditions. The bottom line is that we have these disparate outcomes because the opportunity to be healthy is not equally available everywhere or for everyone in our state. The report’s findings include:

- African American and American Indian babies die in the first year of life at twice the rate of white babies. While infant mortality rates for all groups have declined, the disparity in rates has existed for over 20 years.
- American Indian, Hispanic/Latino, and African American youth have the highest rates of obesity.
- African American and Hispanic/Latino women are more likely to be diagnosed with later-stage breast cancer.
- Gay, lesbian, and bisexual university students are more likely than their heterosexual peers to struggle with their mental health.
- Persons with serious and persistent mental illness die, on average, 25 years earlier than the general public.

These health disparities persist and are neither random nor unpredictable. We know so much more now about

what truly creates health, far beyond insurance coverage and access to clinical care, important as those are. The groups that experience the greatest disparities in health outcomes also experience the greatest inequities in the social and economic conditions that are such strong predictors of health:

- Poverty rates for children under 18 are twice as high for Asian children, three times as high for Hispanic/Latino children, four times as high for American Indian children, and nearly five times as high for African American children as for white children.
- Unemployment is highest among populations of color, American Indians, and people who live in rural Minnesota.
- While 75 percent of the white population in Minnesota owns their own home, only 21 percent of African Americans, 45 percent of Hispanic/Latinos, 47 percent of American Indians, and 54 percent of Asian Pacific Islanders own their own homes.
- Gay, lesbian, bisexual, and transgender youth are at increased risk of bullying, teasing, harassment, physical assault, and suicide-related behaviors compared to other students.
- American Indian, Hispanic/Latino, and African American youth have the lowest rates of on-time high school graduation.
- African Americans and American Indians are incarcerated at nine times the rate of white persons.

The MDH report is clear that the barriers to equal opportunity for optimal health are structural. It was bold in speaking explicitly about the relationship of race to structural inequities. All leaders in the health and health care sector are challenged first to see, and then work to ad-



Perspective from
Jan Malcolm
Stratis Health Board member

The barriers to equal opportunity for optimal health are structural.

dress, the structural racism that is deeply embedded in our history, our society, and our institutions. Structural racism is defined as “the normalization of an array of dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians. It is perpetuated when decisions are made without accounting for how they might benefit one population more than another, or when cultural knowledge, history, and locally generated approaches are excluded.”

The report contains many practical recommendations for public health, health care, and other community partners, with references to evidence and national best practices. As we move farther upstream to improve community conditions, we will reap the benefits of closing other gaps—in education, employment, and economic stability. This “virtuous cycle” of improvement can help fuel even greater improvements in population health, while bringing our national health care expenditures closer in line to those of our global peers (and economic competitors). I can’t think of a more worthy project for our collective efforts. ○

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Technology in Support of Equity

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AS A HEALTH CARE OUTREACH WORKER IN DULUTH two decades ago, I would have gladly traded in my hefty three-ring binder thick with dog-eared pages of community-based organizations and other trusted contacts for a searchable, sortable laptop app to address health care and social determinant needs. Today, online cloud services—like Aunt Bertha, Healthify, and NowPow—are powered by detailed, up-to-date resource databases. These tools allow outreach workers, care coordinators and others to make appropriate referrals faster for clients. These tools offer functionality that tracks whether clients and organizations were successfully connected to address the individual’s needs.

Technology can be an incredible aid for health care organizations to advance equitable care if implemented properly. Stratis Health believes the Institute for Healthcare Improvement’s (IHI) Framework for Health Care Organizations to Achieve Health Equity is a powerful approach for driving equitable quality improvement.

Across the framework’s cores areas, from making health equity a strategic priority to decreasing institutional racism, technology can play a supporting role.

Electronic health record (EHR) systems should be used to identify, communicate, and track gaps in care. Quality of care data needs to be parsed by race, ethnicity, language, and other criteria to unmask

hidden gaps. Overall high screening rates for colorectal cancer for some clinics can become unacceptably low when looked at exclusively for African Americans. A gap revealed is ready for examination to understand and address the issues.

When one revealed gap becomes two, then three or more, they drive the need to make equity a strategic priority. Health care leaders use this evidence to make a business case grounded in their mission of patient care and to reflect the cost of unequal care. BlueCross BlueShield Minnesota published the 2018 report *The Cost of Health Inequities in Minnesota* showing that in our state alone, the cost of inequity is \$2.2 billion.

When organizations become agile and can tap into their EHRs for detailed analyses

and care, and motivate others throughout the organization to seek improvement. Data makes an undeniable case for the culture change needed to reduce institutional racism. It enables people to make better data-driven business and care decisions. Culture change can be augmented by standardized assessments (administered electronically for efficiency, of course!) that help organizations evaluate their current focus on health equity and improvement efforts. From this look at their internal landscape, leaders can unfold their strategic priorities.

Predictive analytics software allows organizations to identify patients at risk for a health crisis before one happens. Care coordinators are using data dashboards from these technology tools on a daily basis to carry out interventions that maintain a person’s health and avoid inappropriate utilization, setting the stage for the right care, at the right time, in the right place.

Patient engagement tools, like portals and open clinical notes, allow patients to access their health information and share with their social supports. Patients can better understand their health issues and shape their preferred approach to care in ways that are appropriate to their cultural values and beliefs, and support systems.

Virtual care delivery is filling the gap more and more in the service of equitable care, bringing care to where people need it. For rural care disparities, telehealth provides care in the absence of nearby specialists, allowing more patients to stay in their communities. Telehealth is rapidly being adopted for the delivery of mental health services. In-person medical interpreters are becoming more challenging to find so remote interpreter services fill the communication need.

The varied collection of emerging technology supports is needed to move health care organizations along the path of providing more equitable care. Stratis Health can guide the way. ○

IHI Framework for Health Care Organizations to Achieve Health Equity

Core Areas
1. Make health equity a strategic priority
2. Develop structures and processes to support health equity work
3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact
4. Decrease institutional racism within the organization
5. Develop partnerships with community organizations

Framework for Health Care Organizations to Achieve Health Equity, Institute for Healthcare Improvement, 2016.

of disparities data and provide high-level dashboards reflecting progress on disparate care, beyond what is reported to MN Community Measurement, we’ll have made significant progress in integrating equity into quality improvement.

Data on disparities gives leaders the ability to paint the picture of uneven outcomes

Minnesota Health Systems Making Health Equity Actionable

AS MINNESOTA'S COMMUNITIES BECOME MORE DIVERSE, health care organizations recognize they must catch up to meet the needs of their changing populations. For some, that means addressing disparities in health outcomes.

"There seems to be a movement in Minnesota and awareness around addressing disparities that I haven't seen in any other state," said Aswita Tan-McGrory, deputy director, The Disparities Solutions Center at Massachusetts General Hospital, which offers a disparities executive education program. Since 2007, 11 Minnesota health care organizations have participated in the program.

Minnesota organizations are trying varied approaches to embed health equity into their processes and cultures.

Disparities data builds awareness

Health care organizations are helping their staff understand that inequities can infiltrate their work. And how, despite best intentions to put patient needs first, they may not be providing optimal care. Disparities data is a starting place to make the case to focus on equity.

Mayo Clinic's electronic health record (EHR) system implementation earlier this year enhanced its quality data team's ability to stratify priority metric data by race, ethnicity, language, (REL) and gender to uncover disparities. "Today, we're really trying to understand how our data can be used to reveal and identify disparities that we know exist within our practice," shared John Knudsen, medical director, Mayo Clinic, Office of Health Equity and Inclusion.

Allina Health started getting traction on addressing health equity when it built REL and other demographic filters into its clinical quality dashboards. "Quantitative data showing disparities in clinical quality outcomes helps engage leaders and clinicians," said Mollie O'Brien,

Allina's director of health equity. "This data comes to life when we pair it with stories from our patients. They help provide insights on what is causing the disparities and how we can work together to create solutions."

"We started including health equity goals within our system-wide Measures of Caring scorecard for quality. That was a game changer," added O'Brien. "If something's on the scorecard, we're saying this matters across our system."

To support benchmarking and transparency from an equity perspective, HealthPartners ranks all of its clinical sites quarterly by achievement of key clinical quality measures for patients of color and patients insured through government programs.

Root cause in the context of culture

As with any quality improvement issue, understanding root causes for health disparities is essential. Staff need the knowledge and skills to navigate across culture, class, race, and language. They need to understand implicit bias and have the cultural competence or intercultural agility to develop interventions addressing underlying health equity issues. Minnesota health care organizations are applying this knowledge to address equity in care.

Allina uncovered statistically significant shorter hospice lengths of stay for some populations. Further investigation showed a lack of minorities in hospice in the first place, leading to the questions of whether referrals were made and whether hospice was rejected. Understanding cultural communities is critical to understanding why



gaps exist. Allina is exploring potential causes such as differences in values and beliefs at end of life related to family care-taking, distrust of the medical system, and implicit bias in clinical decision making.

Mayo took its three key hospital inpatient metrics, stratified them and found statistically significant variations in one or more of those metrics when looked at by REL and gender. Rochester had disparities in readmission rates for its non-English speaking patients. When the issue was deeply explored, Mayo uncovered that patients were often released into the community without connection to a primary care network. Care coordinators now make sure non-English speaking patients have their needs met so they can manage their care after leaving the hospital. Although a disparity remains, readmission rates are trending downward for this population.

"We need our staff to ask, 'Where do culture and care intersect with each other? And, how can we get it right?'" Knudsen said.

Culture change for equity

While data collection, performance measurement, and multifaceted interventions are foundational tools to eliminate disparities, organizations are discovering that culture change is needed to truly address

equity. A study by the Disparities Leadership Program looked at the experiences of 115 organizations that had been through its program. After individual projects were completed, participants often felt there was still some resistance to organizational buy-in about the importance of addressing disparities. The program identified shaping organizational culture as one of five essential domains to successfully address disparities and improve quality of care.

“We realized that health equity work feels so difficult because it’s about transforming how the organization works,” said Tan-McGrory.

Even Federally Qualified Health Centers, which focus on serving diverse populations, find they have disparities in care. Westside Community Health Services wanted to work on its gaps in care. The clinic realized it first needed to take a step back and work on organizational change management.

Health equity has to align with the culture of the organization.

Organizational change management strategies are needed to do that. “We need to weave equity throughout the organization to keep it from being siloed,” said Tan-McGrory.

HealthPartners does just that. Advancing equity is embedded across its strategic plan, with goals for a diverse workplace and decreasing gaps in care. Specific equity measures are built into its executive incentive program.

“We want to have a coordinated organization-wide approach that reinforces that equity is part of everyone’s work,” said Brian Lloyd, strategic initiatives consultant at HealthPartners.

The Diversity & Inclusion workgroup, focused on workforce, and the Health

Equity workgroup, focused on clinical care, work together closely to drive culture change. HealthPartners has leveraged its twice-annual “team talks” to reach all 26,000 employees. Senior leaders have facilitated education and conversations about topics such as equity, diversity, inclusion, and racism. Tools and resources were made available to support subsequent learning and action.

HealthPartners also has 170 self-identified Equitable Care Champions across the organization who serve as point people at their site or on their team to carry forward the message of equity.

Integrating equity into organizational structure

Allina Health prototyped “Health Equity Action and Learning (HEAL),” which began as a four-month program, where cohorts from the different service areas learned as a team about data, cultural competency, implicit bias, understanding root causes using

literature and community and patient engagement, and action plans.

To sustain the work, Allina is integrating elements of the HEAL program into its quality improvement framework and infrastructure by launching a HEAL committee. This group of people from across the organization prioritizes opportunities and engages system stakeholders to take on the work.

Allina’s HEAL committee looks at all of the measures on the system’s Measure of Caring scorecard to determine which are “disparity sensitive” and assesses them for disparity gaps. The committee established prioritization criteria for determining which disparity gaps to take action on. Higher priority is given to opportunities

that have meaningful impact, strategic alignment, operational feasibility, and engaged and passionate people willing to take on the work.

Mayo is building health equity education into its Quality Academy curriculum. As a natural outflow of increased knowledge through that training, Knudsen expects staff will begin to automatically ask how equity plays a role in quality shortfalls.

“Our goal is that in 12 to 18 months we see a significant increase in the number of quality projects that include equity as one of the pillars that are being addressed,” noted Knudsen.

Equity an emerging discipline

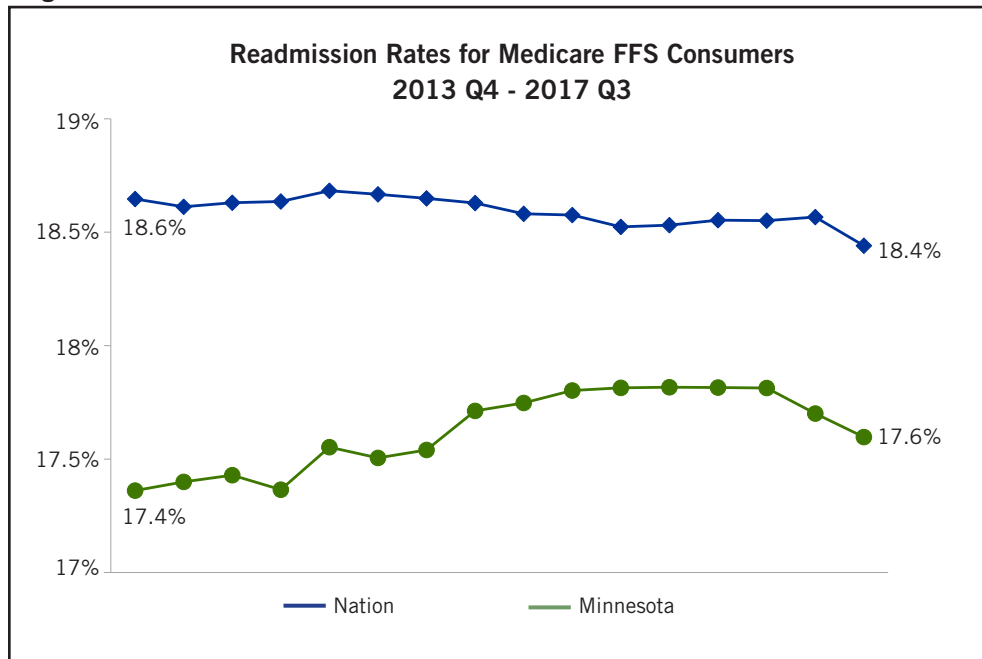
We’ve known about disparities in care for some time. O’Brien likened the integration of an equity focus into an organization to that of the integration of quality. “Fifteen years ago, quality improvement was new, now it’s just part of what we do,” said O’Brien. “While health systems have viewed health equity as a moral imperative for over a decade, figuring out how to activate health equity as a business imperative is new.”

Health equity is an emerging discipline across the country. Looking at quality improvement through a health equity lens requires different approaches. If we want to advance equity, health care organizations need to get out of their care settings and work on community-based interventions. They need to explore social determinants of health and push on their spheres of influence. Health care organizations across Minnesota are at various stages of the journey, and promising changes are underway. ○

“Health equity work feels so difficult because it’s about transforming how the organization works.”

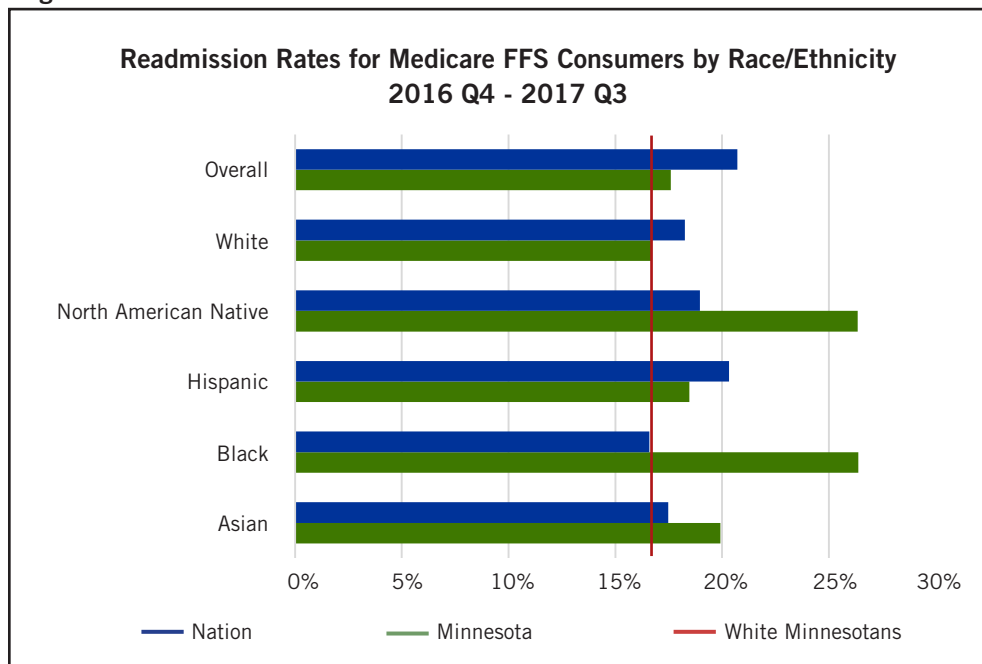
Looking at the numbers: Disparities in Minnesota Hospital Readmission Rates

Figure 1.



Rolling four quarters.

Figure 2.



Source for both charts: Medicare fee-for-service (FFS) 30-day readmission rates, most recent data available. Not risk adjusted. Note: Lower rates are better.

REDUCING HOSPITALIZATIONS HAS LONG BEEN A FOCUS AREA for national and local health care quality improvement efforts. When data from the Centers for Medicare & Medicaid Services (CMS) revealed uneven quality performance across the country, it signaled opportunities for improved care and reduced cost. Much has evolved since CMS first focused on inappropriate hospital admissions in the 1980s. Today, CMS continues its focus on reducing hospitalizations, with attention and incentives to drive down readmissions.

Health care organizations monitor readmissions using numerous methods such as 30-day readmissions overall, as well as readmissions for people discharged to nursing homes or home health agencies, Medicare fee-for-service (FFS) risk-adjusted 30-day readmissions, potentially preventable readmissions (PPRs), and admissions for ambulatory care sensitive conditions, like diabetes and heart failure.

Minnesota remains better than the nation for 30-day unadjusted readmission rates for Medicare FFS beneficiaries, looking at rolling four quarters from fourth quarter (4Q) 2013 through third quarter (3Q) 2017 (Figure 1). Overall Minnesota performs almost a percentage point better than the nation in this most recent data, with readmissions at 17.6 percent for Minnesota compared to 18.4 percent for the nation. In this four year period, national rates have trended down slightly while Minnesota has trended up by a similar margin.

Data stratified through an equity lens Looked at through a health equity lens, Minnesota’s readmissions data stratified by race and ethnicity shows uneven quality performance, signaling opportunities for improved care and reduced cost (Figure 2).

Disparities within Minnesota

In Minnesota, Medicare FFS beneficiaries who identify as being part of a diverse population have notably higher rates of readmissions, compared to the majority white population. The most recent Medicare data available, fourth quarter (4Q) 2016 through third quarter (3Q) 2017, shows the following Minnesota disparities in readmissions rates, compared to whites:

- 1.8 percent worse for Hispanics
- 3.3 percent worse for Asians
- 9.7 percent worse for Blacks
- 9.7 percent worse for North American Natives

Minnesota worse than the nation

Our readmissions disparities story deepens when Minnesota populations are compared to the nation. Minnesota's Hispanic population fares better than Hispanics nationwide, although still performing worse than Minnesota's white population. While white Minnesotans fare somewhat better than the white population nationally, our Asian, Black, and North American Native populations fare worse than their national counterparts.

- 1.7 percent worse for Asians
- 3.2 percent worse for Blacks
- 6.0 percent worse for North American Natives

Data to drive improvement

Health care organizations need to stratify their own readmissions data to uncover disparities masked in overall averages. Armed with that data, discussions about interventions can take a more targeted approach to meet the specific needs and circumstances of adversely affected populations to improve the quality of care for all Minnesotans.

Accelerating Health Care Affordability Event

Cross-Sector Leaders Collaborating to Drive Progress
Thursday, November 29, 2018

Stratis Health, the Institute for Clinical Systems Improvement, and MN Community Measurement invite thought leaders and decision makers in our community, to participate in a community conversation focused on understanding where we are today, and identifying action steps to accelerate health care affordability in our region.

About this Event

As thought leaders and decision makers, we can influence the affordability of health care in our community. Through our collaboration, we will align our efforts and define next steps to advance affordability in our region.

This event is designed for leaders in the private and public sectors responsible for purchasing health care for employees or other beneficiaries, insurers designing benefit plans and engaging provider networks, health care delivery systems providing and coordinating frontline care, and those leading the development of statewide policy.

Participants will:

- Receive the most current data and information on total cost of care at the national and state level.
- Learn about efforts of local organizations focused on advancing affordability, and strategies used by purchasers, providers, consumers, and insurers to improve health, reduce waste, and address price.
- Engage in cross-sector discussions to envision the ideal future state, and identify action steps that can be taken (individually and collectively) to advance affordability.

The event is Thursday, November 29, 2018, 10 a.m. to 2 p.m. at the Crowne Plaza Aire MSP Airport - Mall of America, in Bloomington. Registration required. For more information, contact Sue Severson at 952-853-8538 or sseverson@stratishealth.org.



STRATIS HEALTH NEWS



Jennifer Lundblad and Craig Svendsen, board chair, recognize outgoing board members Mary Jo Kreitzer (top) and Donna Anderson (bottom).

Stratis Health partners to form Superior Health Quality Alliance. To drive continued achievement of Medicare Quality Improvement Organization (QIO) Program goals under the new Network of Quality Improvement and Innovation Contractors (NQIIC) framework, eight organizations have come together to power a new nonprofit organization. Superior Health Quality Alliance is comprised of the Illinois Health & Hospital Association, MetaStar, Michigan Health & Hospital Association, Midwest Kidney Network, Minnesota Hospital Association, MPRO, Stratis Health, and Wisconsin Hospital Association. All have served as either a quality improvement organization, hospital improvement innovation network (HIIN) or end-stage renal disease (ESRD) network. Each organization remains independent and addresses health care issues outside the Medicare QIO Program.

Antibiotic prescribing technical assistance for Johns Hopkins research project. The Agency for Healthcare Research and Quality (AHRQ) is funding a nationwide initiative to optimize use of antibiotics across health care settings. Stratis Health is a partner with NORC, supporting researchers at Johns Hopkins Armstrong Institute for Patient Safety and Quality who aim to identify which approaches are most helpful and operationalize efforts to optimize antibiotic

prescribing. Stratis Health is nearing the final months of the hospital implementation phase of the initiative, where the team has provided support to hospitals in the central and southern United States. Stratis Health is providing input to the national team to support recruitment and launch of the next setting, which is long-term care.

Jane C. Pederson, Stratis Health chief medical quality officer was selected as a fellow for the national Health and Aging Policy Fellows Program. The goal of the Fellows Program is to provide professionals in health and aging with the experience and skills necessary to help lead and shape a healthy and productive future for older Americans, through the translation of cutting-edge science and practical clinical experience into sound health policy.



Stratis Health thanks outgoing board members Donna Anderson, retired director of the Dakota County Public Health Department, and Mary Jo Kreitzer, founder and director of the Earl E. Bakken Center for Spirituality & Healing, who each served six years on the board of directors.

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works toward its mission through initiatives funded by federal and state government contracts, and community and foundation grants, including serving as Minnesota's Medicare Quality Innovation Network - Quality Improvement Organization.

Stratis Health works with the health care community as a quality improvement expert and clearinghouse, educator and trainer, consultant and supporter, convener and facilitator, and data resource.

Contact us to see how we can assist you with your quality improvement needs. Call 952-854-3306 or 1-877-787-2847 (toll-free) or email us at info@stratishealth.org.

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